CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Long Term Care and Community Alternatives

(Amendment)

907 KAR 1:022. Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services [~~the mentally retarded and developmentally disabled level of care criteria~~.]

RELATES TO: 42 C.F.R. 430, 431, 432, 433, 435, 440, 441, 442, 447, 455, 456, 42 U.S.C. 1396a, b, c, d, g, i, l, n, o, p, r, r-2, r-3, r-5, s

STATUTORY AUTHORITY: Executive Order 2004-726, KRS 194A.030(2)[~~(3)~~], 194A.050(1), 205.520(3), 205.558

NECESSITY, FUNCTION, AND CONFORMITY: Executive Order 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services [~~the mentally retarded and~~

~~developmentally disabled level of care criteria~~] for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designee.

(2) " High intensity nursing care services" means care provided to a Medicaid eligible individual who meets high intensity nursing care patient status criteria in accordance with Section 4 of this administrative regulation and by a nursing facility or a nursing facility with waiver participating in the Medicaid Program with care provided in beds also participating in the Medicare program.

(3) "High intensity rehabilitative services" means therapy services which:

(a) Are expected to improve an individual's condition while the individual possesses reasonable potential for improvement in functional capability; and

(b) Do not include restorative and maintenance nursing procedures, including routine range of motion exercises and application of splints or braces by nurses and staff.

(4) "Intermediate care facility for individuals with mental retardation or a developmental disability [~~the mentally retarded and developmentally disabled~~]" or "ICF-MR-DD" means a licensed intermediate care facility for individuals with mental retardation or a developmental disability [~~the mentally retarded and developmentally disabled~~] certified to the Department for Medicaid Services as meeting all standards for an intermediate care facility for individuals with mental retardation or a developmental disability [~~facilities for the mentally retarded and developmentally disabled~~].

(5) [~~(3)~~] "Intermediate care facility for individuals with mental retardation or a devel-

opmental disability [~~for the mentally retarded and developmentally disabled~~] services" means care provided to a Medicaid eligible individual who meets ICF-MR-DD patient status criteria in accordance with Section 4 of this administrative regulation and by an ICF-MR-DD participating in the Medicaid program [~~that is consistent with a combination of the services listed in Section 5 of this administrative regulation~~].

(6) [~~(4)~~] "Intermittent high intensity nursing care [~~skilled nursing care~~] services" means services for an individual who requires high intensity nursing care [~~skilled nursing care~~] services at regular or irregular intervals, but not on a twenty-four (24) hour-per-day basis and not less than three (3) days per week.

(7) “Low intensity nursing care services” means care provided to a Medicaid eligible individual who meets low intensity nursing care patient status criteria in accordance with Section 4 of this administrative regulation and by a nursing facility or a nursing facility with waiver participating in the Medicaid program.

(8) [~~(5)~~] "Medical condition" means a usually-defective state of health relative to a clinical diagnosis made by a licensed physician, physician assistant, or an advanced registered nurse practitioner.

[~~(6) "Nursing care services" means care provided that is consistent with a combination of the services listed in Section 4 of this administrative regulation and that is provided by or under the supervision of technical or professional staff in an institutional setting.~~]

(9) [~~(7)~~] “Nursing facility” or “NF” means:

(a) A facility:

1. To which the state survey agency has granted an NF license;

2. For which the state survey agency has recommended to the department certification as a Medicaid provider; and

3. To which the department has granted certification for Medicaid participation; or

(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and 1396l, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), (d), 42 C.F.R. 447.280 and 482.66.

[~~(8) "Nursing facility level of care" means that care that meets the criteria established in this administrative regulation for inpatient treatment of an individual in a nursing facility and that is based on a medical condition requiring professional or technical nursing care services to be ordered and supervised by a physician, physician assistant, or advanced registered nurse practitioner on an ongoing basis.~~]

(10) [~~(9)~~] "Nursing facility with Medicaid waiver" or "NF-W" means a facility:

(a) To which the state survey agency has granted an NF license;

(b) For which the state survey agency has recommended to the department certification as a Medicaid provider;

(c) To which the department has granted a waiver of the nursing staff requirement; and

(d) To which the department has granted certification for Medicaid participation.

(11) “Patient status” means that an individual possesses care needs in accordance with Section 4 of this administrative regulation for treatment in an institutional setting.

(12) “Personal care” means services to help an individual achieve and maintain good personal hygiene including but not limited to assistance with bathing, shaving, cleaning

and trimming of fingernails and toenails, cleaning of the mouth and teeth and washing, grooming and cutting of hair. [~~(10) "Skilled nursing care services" means care that is consistent with a combination of the services listed in Section 4(2) of this administrative regulation and that is provided on a daily basis by, or under the supervision of, a registered nurse, licensed practical nurse, or certified therapist in an institutional setting.~~

~~(11) "Skilled rehabilitative services" means those therapy services which:~~

~~(a) Are expected to improve an individual's condition while the individual possesses reasonable potential for improvement in functional capability; and~~

~~(b) Do not include restorative and maintenance nursing procedures, including routine range of motion exercises and application of splints or braces by nurses and staff.~~]

(13) [~~(12)~~] "Stable medical condition" means a medical condition which is capable of being maintained in accordance with a planned treatment regimen requiring a minimum amount of medical supervision without significant change or fluctuation in a patient's condition or treatment regimen.

Section 2. Participation Requirements. A facility desiring to participate as a nursing facility, nursing facility with waiver, or ICF-MR-DD shall meet the following requirements:

(1) An application for participation shall be made in accordance with 907 KAR 1:671 and 907 KAR 1:672.

(2) A nursing facility shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare unless the facility has obtained a Medicaid waiver of the nurse staffing requirement. If a nursing facility has less than ten (10) beds certified for Medicaid, all Medicaid certified beds shall also be certified to participate in Medicare.

(3) If a nursing facility which has obtained a Medicaid waiver of the nurse staffing requirements chooses to participate in Medicare, the facility shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare. If less than ten (10) beds are certified for Medicaid, all Medicaid beds shall also be certified to participate in Medicare.

(4) A nursing facility or a nursing facility with waiver shall be required to comply with the preadmission screening and resident review requirements specified in 42 U.S.C. 1396r and 907 KAR 1:755. A facility failing to comply with these requirements shall be subject to disenrollment, with exclusion from participation to be accomplished in accordance with 907 KAR 1:671, 42 C.F.R. 431.153 and 431.154.

(5) A facility shall be required to be certified by the state survey agency as meeting NF, NF-W, or ICF-MR-DD status.

(6) In order to provide specialized rehabilitation services to an individual with a brain injury in accordance with Section 6 [~~7~~] of this administrative regulation, a facility shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

(7) A participating nursing facility shall be certified in accordance with standards and conditions specified in the Medicaid Nursing Facility Services Manual before the facility may operate a unit that provides:

(a) Preauthorized specialized rehabilitation services for a person with a brain injury; or

(b) Care for a person who is ventilator dependent.

Section 3. Payment Provisions. (1) Payment for high intensity nursing care, low intensity nursing care, or [~~nursing care services and~~] ICF-MR-DD services shall be limited

to those services meeting the care definitions established in Section 1 of this administrative regulation.

(2) An NF or NF-W shall receive payment for high intensity nursing care services provided to a Medicaid-eligible individual meeting high intensity nursing care patient status [~~nursing facility level of care~~] criteria if the services are provided in a Medicaid-certified bed also participating in the Medicare program.

(3) An NF or NF-W shall receive payment for low intensity nursing care services provided to a Medicaid-eligible individual meeting low intensity nursing care patient status criteria if the services are provided in a Medicaid participating bed.

(4) [~~(3)~~] An ICF-MR-DD shall receive payments for ICF-MR-DD services only.

Section 4. Determining Patient Status. [~~Nursing Facility Level of Care. The department shall review and evaluate the health status and care needs of an individual in need of inpatient care giving consideration to the~~] A patient status decision shall be based on medical diagnosis, [~~age-related dependencies,~~] care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or noninstitutional services.

(1) For an admission and continued stay an individual shall qualify [~~An individual shall not qualify for Medicaid nursing facility level of care unless the individual is qualified for admission, and continued stay as appropriate,~~] under the preadmission screening and resident review criteria specified in 42 U.S.C. 1396r and 907 KAR 1:755.

(2) An individual shall qualify for high intensity nursing care if: [~~skilled nursing care services if:~~]

(a) On a daily basis:

1. The individual's needs mandate:

a. High intensity [~~Skilled~~] nursing care services; or

b. High intensity rehabilitation [~~Skilled rehabilitative~~] services; and

2. The care can only be provided on an inpatient basis;

(b) The inherent complexity of a service prescribed for an individual exists to the extent that it can be safely or effectively performed only by or under the supervision of technical or professional personnel; or

(c) The individual has an unstable medical condition manifesting a combination of at least two (2) or more of care needs in the following areas:

1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;

2. Nasogastric or gastrostomy tube feedings;

3. Nasopharyngeal and tracheotomy aspiration;

4. Recent or complicated ostomy requiring extensive care and self-help training;

5. In-dwelling catheter for therapeutic management of a urinary tract condition;

6. Bladder irrigations in relation to previously indicated stipulation;

7. Special vital signs evaluation necessary in the management of related conditions;

8. Sterile dressings;

9. Changes in bed position to maintain proper body alignment;

10. Treatment of extensive decubitus ulcers or other widespread skin disorders;

11. Receiving medication recently initiated, which requires high intensity [~~skilled~~] observation to determine desired or adverse effects or frequent adjustment of dosage; or

12. Initial phases of a regimen involving administration of medical gases; or

13. Receiving services which would qualify as high intensity rehabilitation services if provided by or under the supervision of a qualified therapist, for example:

a. Ongoing assessment of rehabilitation needs and potential;

b. Therapeutic exercises which shall be performed by or under the supervision of a qualified physical therapist;

c. Gait evaluation and training;

d. Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility;

e. Maintenance therapy if the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance;

f. Ultrasound, short wave, and microwave therapy treatments;

g. Hot pack, hydrocollator infrared treatments, paraffin baths, and whirlpool (if the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required); or

h. Services by or under the supervision of a speech pathologist or audiologist if necessary for the restoration of function in speech or hearing.

(3) An individual shall be determined to meet low intensity patient status if the individual requires, unrelated to age-appropriate dependencies with respect to a minor, intermittent high intensity nursing care, continuous personal care or supervision in an institutional setting. In making the decision as to patient status, the following criteria shall

be applicable:

(a) An individual with a stable medical condition requiring intermittent high intensity nursing care services not provided in a personal care home shall be considered to meet patient status;;

(b) An individual with a stable medical condition, who has a complicating problem which prevents the individual from caring for himself in an ordinary manner outside the institution shall be considered to meet patient status. For example, an ambulatory cardiac patient with hypertension may be reasonably stable on appropriate medication, but have intellectual deficiencies preventing safe use of self-medication, or other problems requiring frequent nursing appraisal, and thus be considered to meet patient status; or

(c) An individual with a stable medical condition manifesting a significant combination of at least two (2) or more of the following care needs shall be determined to meet low intensity patient status if the professional staff determines that the combination of needs can be met satisfactorily only by provision of intermittent high intensity nursing care, continuous personal care or supervision in an institutional setting:

1. Assistance with wheelchair;

2. Physical or environmental management for confusion and mild agitation;

3. Must be fed;

4. Assistance with going to bathroom or using bedpan for elimination;

5. Old colostomy care;

6. In-dwelling catheter for dry care;

7. Changes in bed position;

8. Administration of stabilized dosages of medication;

9. Restorative and supportive nursing care to maintain the individual and prevent deterioration of his condition;

10. Administration of injections during time licensed personnel is available;

11. Services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care; or

12. Routine administration of medical gases after a regimen of therapy has been established.

(d) An individual shall not be considered to meet patient status criteria if care needs are limited to the following:

1. Minimal assistance with activities of daily living;

2. Independent use of mechanical devices, for example, assistance in mobility by means of a wheelchair, walker, crutch or cane;

3. A limited diet such as low salt, low residue, reducing or another minor restrictive diet; or

4. Medications that can be self-administered or the individual requires minimal supervision.

(4) An individual with a mental illness or mental retardation or a developmental disability meeting the health status and care needs specified in subsections (2) and (3) of this section shall:

(a) Be considered to meet patient status; and

(b) Be specifically excluded from coverage in the following situations:

1. If the department determines that in the individual case the combination of care needs are beyond the capability of the facility and that placement in the facility is inap-

propriate due to potential danger to the health and welfare of the individual, other patients in the facility, or staff of the facility; or

2. If the individual does not meet the preadmission screening and resident review criteria specified in 42 USC 1396r and 907 KAR 1:755 for entering or remaining in a facility.

(5) An individual shall meet ICF MR DD patient status if the individual requires physical or environmental management or rehabilitation for moderate to severe retardation and meets the following criteria:

(a) The individual has significant developmental disabilities and significantly sub-average intellectual functioning and requires a planned program of active treatment to attain or maintain the individual's optimal level of functioning, but does not necessarily require nursing facility or nursing facility with waiver services;

(b) The individual requires a protected environment while overcoming the effects of developmental disabilities and sub-average intellectual functioning while:

1. Learning fundamental living skills;

2. Learning to live happily and safely within his own limitations;

3. Obtaining educational experiences that will be useful in self-supporting activities; or

4. Increasing his awareness of his environment; or

(c) The individual has a psychiatric primary diagnosis or needs if:

1. The individual also has care needs as shown in paragraph (a) or (b) of this subsection;

2. The mental care needs are adequately handled in a supportive environment (i.e.,

the intermediate care facility for individuals with mental retardation or a developmental disability); and

3. The individual does not require psychiatric inpatient treatment;

(6) An individual who does not require a planned program of active treatment to attain or maintain the individual's optimal level of functioning shall not meet ICF MR DD patient status.

(7) An individual shall not be denied for ICF MR DD services solely due to advanced age, or length of stay in an institution, or history of previous institutionalization, if the individual qualifies for ICF MR DD services on the basis of all other factors.

(8) Excluding an individual with mental retardation, for an individual with a developmental disability to qualify for ICF MR DD services, the disability shall have manifested itself prior to the individual's 22nd birthday.

(9) Transfer trauma criteria. A Medicaid recipient in an NF who does not meet the low intensity or high intensity nursing care patient status criteria established in this Section shall not be discharged from an NF if:

(a) The recipient has resided in an NF for at least eighteen (18) consecutive months;

(b) The recipient’s attending physician determines that the recipient would suffer transfer trauma in that his or her physical, emotional or mental well being would be compromised by a discharge action as a result of not meeting patient status criteria; and

(c) The department confirms the recipient’s attending physician’s assessment regarding the trauma caused by possible discharge from the NF.

(10) A Medicaid recipient who meets transfer trauma criteria in accordance with sub-

section (9) of this Section:

(a) Shall remain in an NF and continue to be covered by the department for provider reimbursement at least until his or her subsequent transfer trauma assessment; and

(b) Be reassessed for transfer trauma every six (6) months.

(11) The recipient transfer trauma criteria established in subsection (9) of this Section shall not apply to an individual who resides in a facility which experiences closure or a license or certificate revocation.

~~[(3) An individual with a stable medical condition manifesting a combination of at least three (3) of the following care-need categories shall be determined to meet nursing facility level of care:~~

~~(a) Mobility. To demonstrate a care need in this category, an individual shall meet at least one (1) of the three (3) conditions listed below to satisfy this one (1) care-need category:~~

~~1. Assistance with wheelchair. The individual is incapable of propelling a manual wheelchair using upper or lower extremities or incapable of operating a powered wheelchair independently;~~

~~2. Changes in bed position or transfer. The individual is incapable of turning in bed or transferring to or from bed, chair or toilet without physical assistance being provided by another on an ongoing basis (at least three (3) times weekly); or~~

~~3. Ambulation. The individual requires standby assistance from at least one (1) person while walking;~~

~~(b) Physical or environmental management for confusion or agitation. The individual requires staff intervention due to an established pattern of aggressive or disruptive be-~~

~~havior that presents a substantial physical risk to self or others;~~

~~(c) Must be fed. The individual is incapable of taking food from a plate to his or her mouth without assistance of another person. Assistance includes the actual feeding of the individual or verbal assistance to the extent that, without continuous presence and repetitive verbal instructions to the individual, he or she would require to be fed;~~

~~(d) Assistance with going to bathroom or using bedpan for elimination. The individual requires the physical assistance of another person for elimination or to use a bedpan or to perform incontinence care, ostomy care, or catheter care on an ongoing basis (three (3) or more times each week);~~

~~(e) Administration of stabilized dosages of medication. The individual is not mentally or physically capable of self-administration of prescribed medications despite the availability of limited assistance of another person. Limited assistance shall include reminding when to take medications, filling a medication box, encouragement to take medications, reading labels, and opening bottles;~~

~~(f) Requires restorative and supportive nursing care to maintain the individual and prevent deterioration of his or her condition by means of a planned program administered by nursing staff, such as range of motion exercises and application of splints, when prescribed, that the patient is unable to apply by him or herself;~~

~~(g) Administration or preparation of injections by licensed personnel, either due to the nature of the injection or due to the inability of the individual. An individual shall have a physical or mental limitation that prevents him or her from preparing or self-administering injections even with appropriate training;~~

~~(h) Services that could ordinarily be provided or administered by the individual but~~

~~due to the individual's physical or mental condition, the individual is incapable of providing self-care. This shall include daily total hands-on assistance with bathing, dressing, or grooming by a person other than the individual; or~~

~~(i) Cognition and communication. The individual is disoriented as to self or place or is incapable of communicating basic needs and wants (such as need for assistance with toileting, presence of pain) using oral or written language. Illiteracy shall not meet this requirement.~~

~~(4) An individual shall not be considered to meet nursing facility level of care criteria if care needs are limited to:~~

~~(a) Limited assistance with activities of daily living, for example, bathing, dressing, or grooming;~~

~~(b) Independent use of mechanical devices; for example, assistance in mobility by means of a wheelchair, walker, crutch or cane;~~

~~(c) A limited diet, for example, low salt, low residue, reducing or another minor restrictive diet;~~

~~(d) Medications or therapies that can be self-administered or the individual requires minimal supervision;~~

~~(e) General supervision;~~

~~(f) Routine use of oxygen (as needed, continuous, or at night); or~~

~~(g) Limited ability to perform instrumental activities of daily living (IADL), for example, meal preparation, homemaking, or doing laundry.~~

~~(5) An individual with a mental illness, mental retardation, or a developmental disability meeting the health status and care needs specified in this section shall:~~

~~(a) Be considered to meet nursing facility level of care criteria; and~~

~~(b) Be specifically excluded from coverage in the following situations:~~

~~1. If the department determines that in the individual case the combination of care needs are beyond the capability of the facility, and that placement in the facility is inappropriate due to potential danger to the health and welfare of the individual, other patients in the facility, or staff of the facility;~~

~~2. If the nursing care needs result directly and specifically from a mental illness, mental retardation, or a developmental disability; or~~

~~3. If the individual does not meet the preadmission screening and resident review criteria specified in 42 U.S.C. 1396r and 907 KAR 1:755 for entering or remaining in a facility.~~

~~Section 5. Determining ICF-MR-DD Level of Care. An individual shall be determined to meet ICF-MR-DD level of care for an ICF-MR-DD if the individual requires physical or environmental management or rehabilitation for moderate to severe retardation. In making the decision as to ICF-MR-DD level of care, the following criteria shall apply:~~

~~(1) An individual with significant developmental disabilities or significantly subaverage intellectual functioning who requires a planned program of active treatment to attain or maintain the individual's optimal level of functioning but does not necessarily require NF or NF-W services, shall be considered to meet ICF-MR-DD level of care.~~

~~(2) An individual requiring a protected environment while overcoming the effects of developmental disabilities or subaverage intellectual functioning shall be considered to meet ICF-MR-DD level of care while:~~

~~(a) Learning fundamental living skills;~~

~~(b) Learning to live happily and safely within his or her own limitations;~~

~~(c) Obtaining educational experiences that will be useful in self-supporting activities;~~ ~~or~~

~~(d) Increasing his or her awareness of his or her environment.~~

~~(3) An individual with a psychiatric primary diagnosis or needs shall be considered to meet ICF-MR-DD level of care if:~~

~~(a) The individual also has care needs as described in subsection (1) or (2) of this section;~~

~~(b) His or her mental care needs can be adequately handled in an ICF-MR-DD; and~~

~~(c) He or she does not require psychiatric inpatient treatment.~~

~~(4) An individual who does not require a planned program of active treatment to attain or maintain his or her optimal level of functioning shall not be considered to meet ICF-MR-DD level of care.~~

~~(5) An individual shall not be denied ICF-MR-DD level of care solely due to advanced age, length of stay in an institution, or history of previous institutionalization, if the individual qualifies for ICF-MR-DD level of care on the basis of all other factors.~~

~~(6) Excluding an individual with mental retardation, for an individual with a developmental disability, the disability shall have manifested itself prior to the individual's 22nd birthday.~~]

Section 5. [~~6.~~] Reevaluation of Need for Service. (1) Nursing facility, nursing facility with waiver, or ICF-MR-DD services shall continue to be provided to an individual if his or her health status and care needs are within the scope of program benefits as described in Sections 3 and 4 [~~, 4 and 5~~] of this administrative regulation.

(2) An individual's patient status [~~The nursing facility or ICF-MR-DD level of care status of an individual~~] shall be reevaluated at least once every six (6) months.

(3) If a reevaluation of care needs reveals that an individual no longer requires high intensity nursing care, low intensity nursing care, or intermediate care for an individual with mental retardation or a developmental disability:

(a) Payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care; and

(b) Ten (10) days from the date of the reevaluation, payment shall no longer be appropriate in the facility.

Section 6. [~~7.~~] Requirements, Standards and Preauthorization of Specialized Rehabilitation Services for Individuals with Brain Injuries. An individual who has a brain injury [~~is brain injured~~] and meets the high intensity nursing care patient status criteria established in Section 4 of this administrative regulation [~~nursing facility level of care criteria~~] or is qualified under subsection (5) of this section shall be provided care in a certified unit providing specialized rehabilitation services for persons with brain injuries (i.e., brain injury unit) if the care is preauthorized by the department using criteria specified in this section. For coverage to occur, authorization of coverage shall be granted prior to admission of the individual with the brain injury into the certified brain injury unit, or if previously admitted to the unit with other third party coverage, authorization shall be granted prior to exhaustion of those benefits.

(1) Injuries within the scope of benefits shall be:

(a) Central nervous system injury from physical trauma;

(b) Central nervous system damage from anoxia or hypoxic episodes; or

(c) Central nervous system damage from an allergic condition, toxic substance or another acute medical or clinical incident.

(2) The following items shall be indicators for admission and continued stay:

(a) The individual sustained a traumatic brain injury with structural, nondegenerative brain damage and is medically stable;

(b) The individual shall not be in a persistent vegetative state;

(c) The individual demonstrates physical, behavioral, and cognitive rehabilitation potential;

(d) The individual requires coma management; or

(e) The individual has sustained diffuse brain damage caused by anoxia, toxic poisoning, or encephalitis.

(3) The determination as to whether preauthorization is appropriate shall be made taking into consideration the following:

(a) The presenting problem;

(b) The goals and expected benefits of the admission;

(c) The initial estimated time frames for goal accomplishment; and

(d) The services needed.

(4) The following list of conditions shall not be considered brain injuries requiring specialized rehabilitation under this section:

(a) A stroke treatable in a nursing facility providing routine rehabilitation services;

(b) A spinal cord injury in which there is no known or obvious injury to the intercranial central nervous system;

(c) Progressive dementia or other mentally impairing condition;

(d) Depression or psychiatric disorder in which there is no known or obvious central nervous system damage;

(e) Mental retardation or birth defect related disorder of long standing; or

(f) Neurological degenerative, metabolic or other medical condition of a chronic, degenerative nature.

(5) An individual may qualify for coverage under the brain injury program if:

(a) He or she has a stable medical condition with complicating care needs which prevent the individual from caring for him or herself in an ordinary manner outside an institution;

(b) The individual has sufficient neurobehavioral sequelae resulting from the brain injury which when taken in combination require specialized rehabilitation services; and

(c) if the following criteria are met:

1. The individual shall not have previously received specialized rehabilitation services (an individual discharged for the purpose of transfer to another brain injury facility shall not be considered to have "previously received specialized rehabilitation services") as established in this section;

2. The individual shall have the potential for rehabilitation;

3. The care shall be prior authorized on an individual basis by the department; and

4. The care shall be authorized for no more than six (6) months at any one (1) time.

Section 7. [~~8.~~] Requirements, Standards and Preauthorization of Certified Distinct-part Nursing Facility Ventilator Services. An individual who is ventilator dependent and meets the high intensity nursing care patient status criteria [~~requires the skilled nursing care services~~] established in Section 4(2) of this administrative regulation [~~criteria~~] shall

be provided care in a certified distinct-part ventilator nursing facility unit providing specialized ventilator services if the care is preauthorized using criteria specified in this section and the Medicaid Nursing Facility Services Manual.

(1) To participate in the Medicaid Program as a distinct-part nursing facility ventilator service provider:

(a) A nursing facility shall operate a program of ventilator care within a certified distinct-part nursing facility unit which meets the needs of all ventilator patients admitted to the unit; and

(b) A certified distinct-part nursing facility unit shall:

1. Not have less than twenty (20) beds certified for the provision of ventilator care;

2. Be required to have an average patient census of not less than fifteen (15) patients during the calendar quarter preceding the beginning of the facility's rate year or the quarter for which certification is being granted in order to qualify as a distinct-part ventilator nursing facility unit;

3. Have a ventilator machine owned by the facility for each certified bed with an additional backup ventilator machine required for every ten (10) beds; and

4. Have an appropriate program for discharge planning and weaning from the ventilator.

(2) The following items shall be the patient criteria and treatment characteristics for a distinct-part ventilator nursing facility:

(a) An individual shall be considered ventilator (or respiration stimulating mechanism) dependent if the individual:

1. Requires:

a. This mechanical support for twelve (12) or more hours per day; and

b. Twenty-four (24) hours per day high intensity [~~skilled~~] specialty nursing care; or

2. Is in an active weaning program ordered by and under the management of a physician and reviewed and approved by the department; and

a. The goal of the active weaning program is to attain the least mechanical support in the least invasive manner that is consistent with the maximal function of the individual and ultimately no mechanical respiratory support;

b. The individual demonstrates steady progress in decreasing the number of hours and dependence upon the ventilator (or respiration stimulating mechanism) as documented in the individual's physician and nursing progress notes; and

c. The individual requires twenty-four (24) hours per day high intensity [~~skilled~~] specialty nursing care.

(b) An individual shall not be considered ventilator dependent due to being in an active weaning program if:

1. The individual is no longer demonstrating steady progress in decreasing the number of hours and dependence upon the ventilator (or respiration stimulating mechanism); or

2. The individual has been off the ventilator (or respiration stimulating mechanism) for seventy-two (72) consecutive hours.

(c) An admission from hospitalization or other location shall demonstrate two (2) weeks clinical and physiologic stability including applicable weaning attempts prior to transfer.

(d) A physician's order shall specify that the services shall not be provided in an al-

ternative setting due to the medical stability and safety needs of the individual.

(3) A patient status [~~nursing facility level of care~~] determination shall be made taking into consideration the following factors and those defined in the Medicaid Nursing Facility Services Manual, Section IV-B, C and D:

(a) Alternative care possibilities;

(b) Goals for patient care;

(c) Primary hypoventilation, restrictive lung, ventilatory muscular dysfunction, or obstructive airway disorders needs which may necessitate mechanical ventilator and related care;

(d) Nonhospital management factors and needs;

(e) Patient treatment characteristics;

(f) Home care potential;

(g) Suitability of transfer to the ventilator care unit;

(h) Provision of an appropriate place of care; and

(i) Other facility admission indicators as established in the Medicaid Nursing Facility Services Manual.

Section 8. [~~9.~~] Denial of Patient Status [~~Nursing Facility and ICF-MR-DD Level of Care~~]. If an individual does not meet Medicaid criteria for admission or continued stay in a nursing facility or ICF-MR-DD, the individual may appeal the denial in accordance with 907 KAR 1:563.

Section 9. [~~10.~~] Reserved Bed Days. The department shall cover reserved bed days in accordance with the following criteria.

(1) In accordance with subsection (3) of this section, reserved bed days, per resi-

dent, for an NF or an NF-W shall be covered for a maximum of:

(a) Fourteen (14) days per temporary absence due to hospitalization, with an overall maximum of forty-five (45) days during a calendar year; and

(b) Fifteen (15) days during a calendar year for leaves of absence other than hospitalization.

(2) In accordance with subsection (3) of this section, for an ICF-MR-DD:

(a) Reserved bed days, per resident, for an ICF-MR-DD shall:

1. Be covered for a maximum of forty-five (45) days [~~per provider~~] within a calendar quarter; and

2. Not exceed fifteen (15) days per stay due to hospitalization; and

(b) More than thirty (30) consecutive reserved bed days due to hospitalization plus leave of absence or due to leave of absence shall not be approved for coverage.

(3) Coverage during an individual's absence due to hospitalization or due to leave of absence shall be contingent upon the following conditions being met:

(a) The individual shall:

1. Be in Medicaid payment status in the level of care he or she is authorized to receive; and

2. Have been a resident of the facility at least overnight;

(b) An individual for whom Medicaid is making Medicare coinsurance payments shall not be considered to be in Medicaid payment status for purposes of this policy;

(c) The individual shall be reasonably expected to return to the same level of care;

(d) Due to demand at the facility for beds at that level, there shall be a likelihood that the bed would be occupied by another patient were it not reserved;

(e) The hospitalization shall be for treatment of an acute condition, and not for testing, brace-fitting, or another noncovered service;

(f) For a leave of absence other than for hospitalization, the individual's plan of care shall include a physician's order providing for leave; and

(g) A leave of absence shall include a visit with a relative or friend, or a leave to participate in a state-approved therapeutic or rehabilitative program.

Section 10. [~~11.~~] Preadmission Screening and Resident Review. (1) Prior to admission of an individual, an NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

(2) Compliance with 907 KAR 1:755 shall be required in order for an individual to be admitted to an NF.

Section 11. [~~12.~~] Incorporation by Reference. (1) "Medicaid Nursing Facility Services Manual", Department for Medicaid Services, August 2004 [~~April 2003~~] edition, is incorporated by reference.

(2) It may be inspected, copied, or obtained, subject to applicable law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

Date

Russ Fendley, Commissioner
Department for Medicaid Services

Date

Dr. Duane Kilty
Undersecretary for Administration and Fiscal Affairs

Date

James. W. Holsinger, Jr., MD, Secretary
Cabinet for Health and Family Services

907 KAR 1:022

A public hearing on this administrative regulation shall, if requested, be held on September 21, 2004, at 9:00 a.m. EDT in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by September 14, 2004, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business October 1, 2004. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

Jill Brown
Cabinet Regulation Coordinator
Cabinet for Health and Family Services
Office of the Counsel
275 East Main Street - 5W-B
Frankfort, Kentucky 40621
(502) 564-7905
(502) 564-7573 (Fax)

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:022
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen or Teresa Goodrich (564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the provisions relating to nursing facility (NF) and intermediate care facility for individuals with mental retardation or a developmental disability (ICF MR DD) services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
(b) The necessity of this administrative regulation: This administrative regulation is necessary in order to establish the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of authorizing statutes by establishing the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of statutes by establishing the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The service criteria in effect prior to April 2003 has been reinstated in order to enable the Department for Medicaid Services (DMS) to maximize the number of recipients to be served by the nursing facility and home and community based waiver service programs with the limited resources available to DMS.
(b) The necessity of the amendment to this administrative regulation: The amendment to this administrative regulation is necessary to enable DMS to maximize the number of medically needy recipients to be served by the nursing facility and home and community based HCB waiver service programs with the limited resources available to DMS.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation conforms to the content of authorizing statues by revising qualifying requirements regarding NF care in order to enhance recipient access to services within the limited resources

available to DMS.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation will assist in the effective administration of the statutes by revising qualifying requirements regarding NF care in order to enhance recipient access to services within the limited resources available to DMS.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Approximately 275 nursing facilities serving over 16,000 Medicaid recipients currently participate in the Medicaid nursing facility program and approximately 115 home and community based waiver providers serve over 15,000 individuals via the Medicaid home and community based waiver program.

(4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: The amendment to this administrative regulation restores the qualifying requirements that were in effect prior to April 2003; thus, individuals who had qualified prior to April 2003 but were then denied would be expected to qualify again barring a significant improvement in health condition or other unforeseen circumstance. DMS estimates that over 3,500 individuals (including individuals who had previously qualified as well as new applicants) have been denied services as a result of the criteria implemented April 2003. As a result of the amendment to this administrative regulation, any such individual will be evaluated based on the criteria in effect prior to April 2003. Additionally any current recipients will be evaluated based on the prior to April 2003 criteria during their next re-evaluation.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS estimates that the amendment to this administrative regulation will result in a cost of approximately $9.91 million annually ($6.92 million federal funds; $2.99 million state funds).

(b) On a continuing basis: DMS estimates that the amendment to this administrative regulation will result in a cost of approximately $9.91 million annually ($6.92 million federal funds; $2.99 million state funds).

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of revenue to be utilized to implement and enforce this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding will be necessary to implement the

amendments to this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor directly or indirectly increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The "equal protection" and "due process" clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

FEDERAL MANDATE ANALYSIS COMPARISON

Reg. No. 907 KAR 1:022 Agency Contact: Stuart Owen or Teresa Goodrich at 502-564-6204

1. Federal statute or regulation constituting the federal mandate.

   Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

2. State compliance standards.

   This administrative regulation revises the Department for Medicaid Services qualifying requirements regarding nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability (ICF MR DD) services.

3. Minimum or uniform standards contained in the federal mandate.

   This administrative regulation revises the Department for Medicaid Services qualifying requirements regarding nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability (ICF MR DD) services.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

   No. This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

   No additional standard or responsibilities are imposed.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:022
Summary of Material Incorporated by Reference

The Medicaid Nursing Facility Services Manual (August 2004 edition) which is being revised is used by agency staff and participating providers. The manual contains 155 pages. It is divided into five sections and also an appendix which includes provider forms.

Section II – Updated division title and cabinet title

Section III – deleted the requirement for level of care recertification upon readmission to a nursing facility when a Medicaid recipient has left the facility due to an acute care hospital stay for three (3) or more days, updated language, and clarified other policy.

Section IV – Reinserted previous criteria into manual to keep manual consistent with the administrative regulation, deleted exclusion from coverage related to individuals with mental illness, mental retardation or a developmental disability and added transfer trauma criteria language into the manual to render it consistent with the regulation

Section IV-A – Updated cabinet title

Section V – Deleted inhalation therapy from list of ancillary services.

Appendix
The following form is new and is being added to the material incorporated by reference:
“MAP-4105, Application for Transfer Trauma Exemption, January 23, 2004 edition”.
This is a new form to be utilized by attending physicians to document whether or not a Medicaid recipient meet transfer trauma criteria. It shall be completed by a recipient’s attending physician and submitted to the department. This is a one (1) page form.

The “MAP-726, Nursing Facility Request for Admission, April 2002 edition” has been replaced by the “MAP-726A, Nursing Facility Level of Care Request for Admission, September 2003 edition”. The formerly four (4) – page form is now a seven (7) - page form and is utilized to request admission of an individual into a nursing facility. The form has been reformatted and a segment addressing nursing rehabilitative/restorative are has been added to the form.